

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G699		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/28/2012	
NAME OF PROVIDER OR SUPPLIER  ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0000	<p>This visit was for investigation of complaint #IN00109107.</p> <p>Complaint #IN00109107: Substantiated. Federal and state deficiency related to the allegation is cited at W331.</p> <p>Dates of Survey: June 25, 26, 27, and 28, 2012.</p> <p>Facility Number: 003132 Provider Number: 15G699 AIMS Number: 200372010</p> <p>Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP</p> <p>This deficiency also reflects a state finding in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 7/6/12 by Tim Shebel, Medical Surveyor III.</p>			W0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) by not ensuring client A received nursing services according to his medical needs by not providing a policy/procedure to check for feeding tube placement prior to administration of medications/feedings in order to ensure the feeding tube was not occluded.</p> <p>Findings include:</p> <p>On 06/25/12 at 2:37 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>05/25/12: A BDDS report submitted 05/25/12 for an incident on 05/24/12 at 8:00 AM indicated the following regarding client A: "H &amp; S (Health &amp; Safety) Tech at North called the Director of H &amp; S and stated that staff was unable to get any fluids threw his feeding tube. Director of H &amp; S went to North and assess (sic) the consumer and was unable to get any fluids threw consumer feeding tube. Consumer showed no signs of distress. Dr [PCP (Primary Care</p>		W0331	<p>Please see attached documents referring to the policy and procedures for giving medications and tube feeding. 8/22/12In reference to correction response All DSP's will be trained onhow to administer food and medications by tube feeding. To ensure future compliance, the nurse will monitor staff through daily logs and monitor staff quarterly and as needed. 8/28/12Community Services Nurse has implemented a tracking system for feeding tube input which includes liquids amounts, nutritional supplement amounts, and medication amounts to be tracked for each feeding session. Community Services Nurse will train staff on feeding and tracking for use with a peg tube. To ensure future compliance, staff will submit tracking to the Community Services Nurse daily for four weeks and at least weekly thereafter. At this time there are no clients that have a peg tube ordered and for any future needs with a peg tube system ordered for any consumer at The ARC NWI, this system will be implemeneted.</p>		08/14/2012	

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	<p>Physician)] was notified by Director of H &amp; S and new order was received to send consumer for chest x-ray and verification of placement of his feeding tube. Consumer was taken to [hospital] and chest x-ray was done, hospital staff called Dr [PCP] and consumer was admitted. Consumer expired on 05/25/12."</p> <p>Client A's records were reviewed on 06/26/12 at 12:10 PM. Client A's record review included review of the following dated documents:</p> <p>Cumulative Medical Record indicated the following:</p> <p>02/10/12: Client A had a PEG (percutaneous endoscopic gastrostomy) tube placed at the hospital.</p> <p>03/05/12: Client A discharged from the hospital with diagnoses that included, but were not limited to: Hospital acquired pneumonia, Malnutrition and Failure to Thrive.</p> <p>05/20/12: Client A accidentally pulled out the PEG tube during his bath, was taken by ambulance to the hospital and the feeding tube was put back in place.</p> <p>05/24/12: Client A's tube was not working properly and there was difficulty</p>						

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	<p>with getting fluids through the tube.</p> <p>05/24/12: Client A was taken to the hospital for an x-ray to check tube placement and he was admitted for evaluation and treatment.</p> <p>05/24/12: Hospital records indicated, "Nonfunctioning PEG tube, unable to aspirate or inject. "PEG tube noted to be occluded."</p> <p>Client A's 05/2012 MAR (Medication Administration Record) indicated, "Flush feeding tube with 110 cc (cubic centimeter) water every 8 hours. The MAR did not indicate staff were to check for tube placement prior to feeding or medication administration.</p> <p>Client A's record contained the undated document, "Instructions for Giving Medications and Feeding with J-Tube (jejunostomy)." The document contained the following steps:</p> <p>"1. After staff has gathered all equipment needed for giving meds and tube feeding</p> <p>2. Using the syringe flush the tube with 30ml (milliliter) of warm tap water (flushing the tube before any feeding or medications will allow staff to make sure that the tube is unclogged).</p> <p>3. Crush each pill individually and dissolve in 15cc of warm tap water</p>						

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	<p>4. Remove the three way knob from tubing, (make sure that you pinch the tubing to avoid fluids from coming out) attach the plunger syringe into the opening of J-Tube (Hold the syringe straight up) this will allow gravity to pull the fluids into the stomach.</p> <p>5. Slowly pour the dissolve (sic) medication into the syringe, repeat #3 for each individual pill.</p> <p>6. All liquid medications must be given through the syringe also.</p> <p>7. After each medication slowly pour 15cc of warm tap water into the syringe, this will help prevent the tube from getting blocked.</p> <p>8. When giving Jevity (liquid feeding) remove the three way knob, Using the syringe flush tube with 30ml of warm tap water FIRST, then attach plunger syringe into the opening of the J-Tube (Hold the syringe straight up) this will allow gravity to pull the Jevity into the stomach. (This feeding may take up to 3-5 minutes or more to complete this is normal)</p> <p>9. After the Jevity feeding make sure that you flush the tubing with 30ml of warm tap water</p> <p>10. When medication and feeding are complete replace the three way knob back on the J-Tube.</p> <p>11. Clean your supplies by rinsing the syringe and bottle with cool water. Then swish with warm water and a small</p>						

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	<p>amount of liquid dishwashing soap. Rinse well and let air dry.</p> <p>12. Staff is to administer 240ml (one can) of Jevity four times a day @ 7am, 11am, 3pm and 7pm</p> <p>13. [Client A] will remain NPO (nothing by mouth) until his next cookie swallow, if staff needs (sic) to administer any medications by mouth make sure that you crush each pill and give it with applesauce."</p> <p>The policy did not check for tube placement or residual.</p> <p>On 06/26/12 at 1:34 PM an interview with the Registered Nurse (RN) was conducted. She indicated the instructions for giving medications and feeding with a J-tube for client A, did not give instructions to check for placement or residual, nor instructions on how to do that. She indicated the J-tube should always be checked for placement prior to administration of any fluids. She indicated the records of client A indicated the client was having problems on the morning of 05/24/11 and he was evaluated at the hospital, admitted and later died in the AM of 05/25/12.</p> <p>9-3-6(a)</p>						